

Division of Family & Children Services: Child Death Report for 2nd Quarter 2013

Date of Report: September 30, 2013



Georgia Department of Human Services

Vision, Mission and Core Values

Vision

Stronger Families for a Stronger Georgia.

Mission

Strengthen Georgia by providing Individuals and Families access to services that promote self-sufficiency, independence, and protect Georgia's vulnerable children and adults.

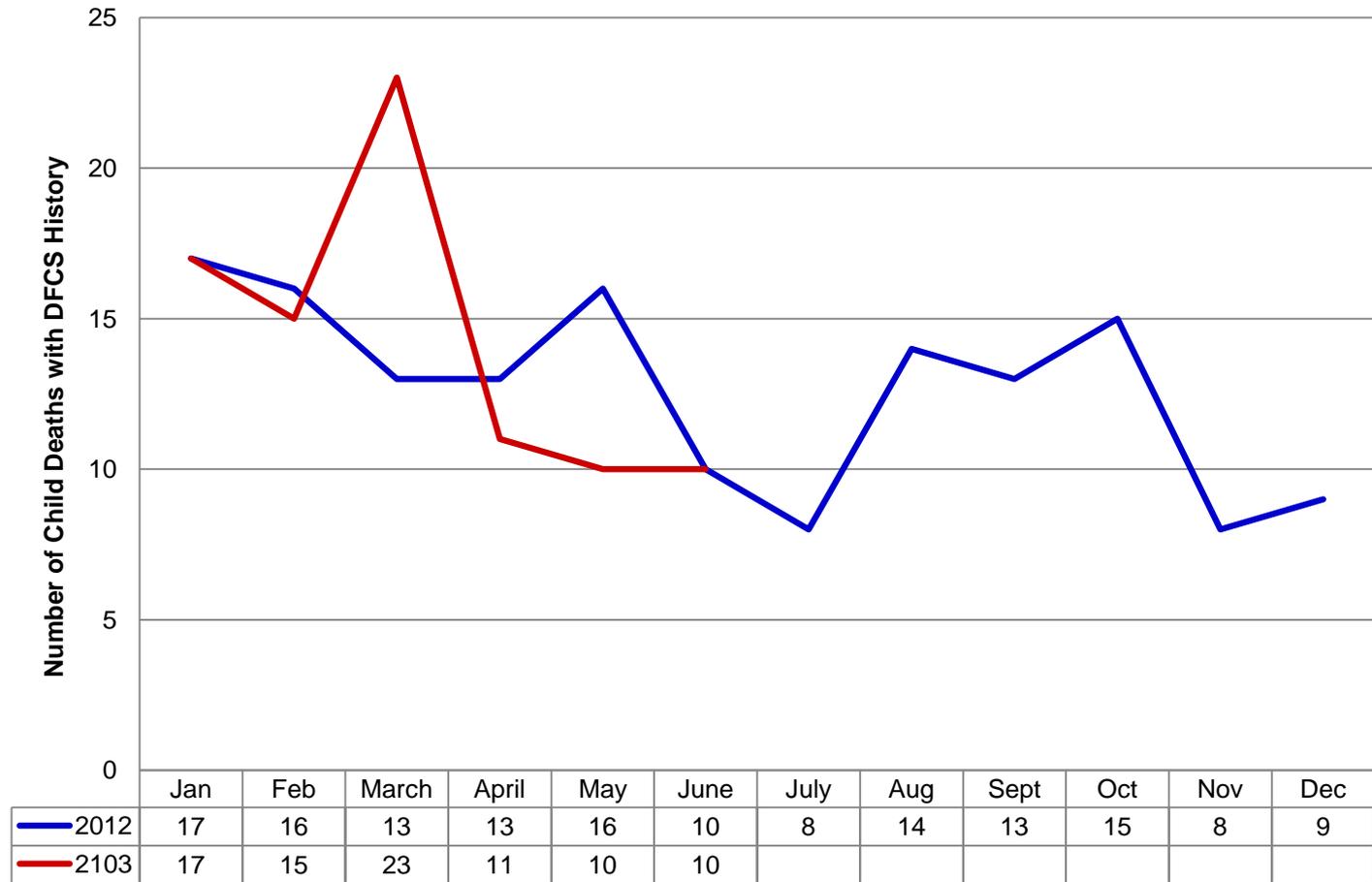
Core Values

- **Provide access to resources that offer support and empower Georgians and their families.**
- **Deliver services professionally and treat all clients with dignity and respect. Manage business operations effectively and efficiently by aligning resources across the agency.**
- **Promote accountability, transparency and quality in all services we deliver and programs we administer.**
- **Develop our employees at all levels of the agency.**

Summary: Child Deaths with Prior DFCS History

- Of the 31 deaths reported to DFCS during the 2QTR13, 51% due to accidents or natural causes
- Sleep-related deaths accounted for 10 of 31 *known* causes
- 4 children were in foster care at the time of death; all 4 deaths related to existing medical conditions prior to foster care entry
- Significantly fewer deaths during 2QTR (31) than 1QTR (55)
- Number of deaths in first 6 months of 2013 (86) almost identical to first 6 months of 2012 (85)

Child Deaths in 2012 & 2013



Child Death Comparison between 2012 & 2013

While there was a fairly significant increase in the number of deaths in the 1QTR of this year, due to a decline in the 2QTR, the trend for total deaths in 2012 and 2013 are almost identical

| Year | 1 st QTR | 2 nd QTR | Total |
|------|---------------------|---------------------|-------|
| 2012 | 46 | 39 | 85 |
| 2013 | 55 | 31 | 86 |

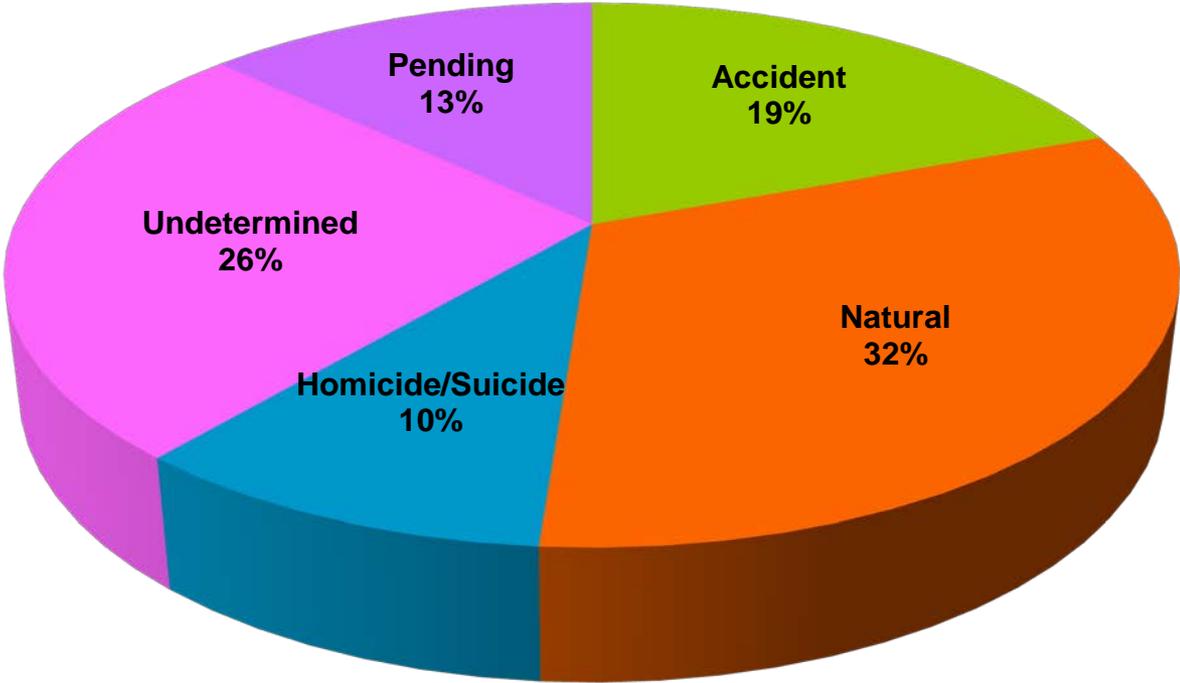
Note: This information reflects only those children in families who had any DFCS / child welfare involvement during the five years prior to the death occurring

Child Deaths Classified by Cause and Manner

- **Cause of Death** - a forensic finding of how the death occurred, e.g. drowning, gunshot, suffocation, etc
- **Manner of Death** - an official finding of how the cause of death arose:
 - Accidental
 - Homicide
 - Natural
 - Suicide
 - Undetermined (when it is medically impossible to establish the circumstances of death)

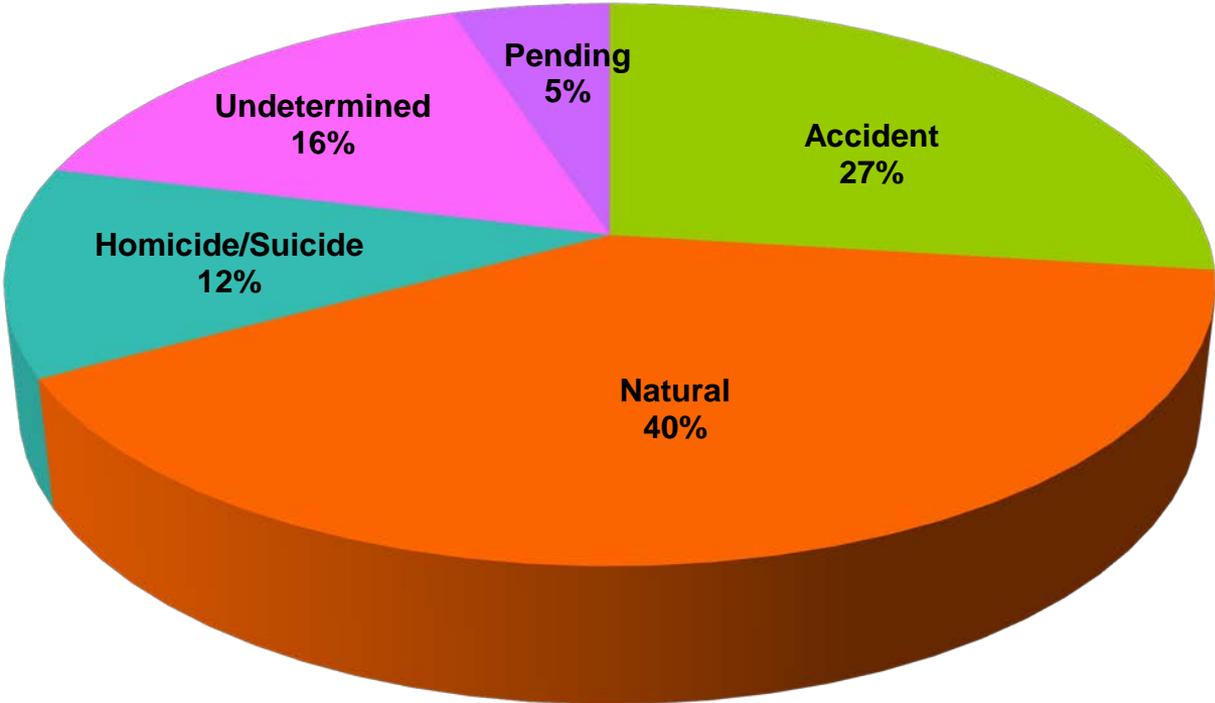
Manner of Child Deaths for 2QTR13 (N=31)

Manner of Child Deaths

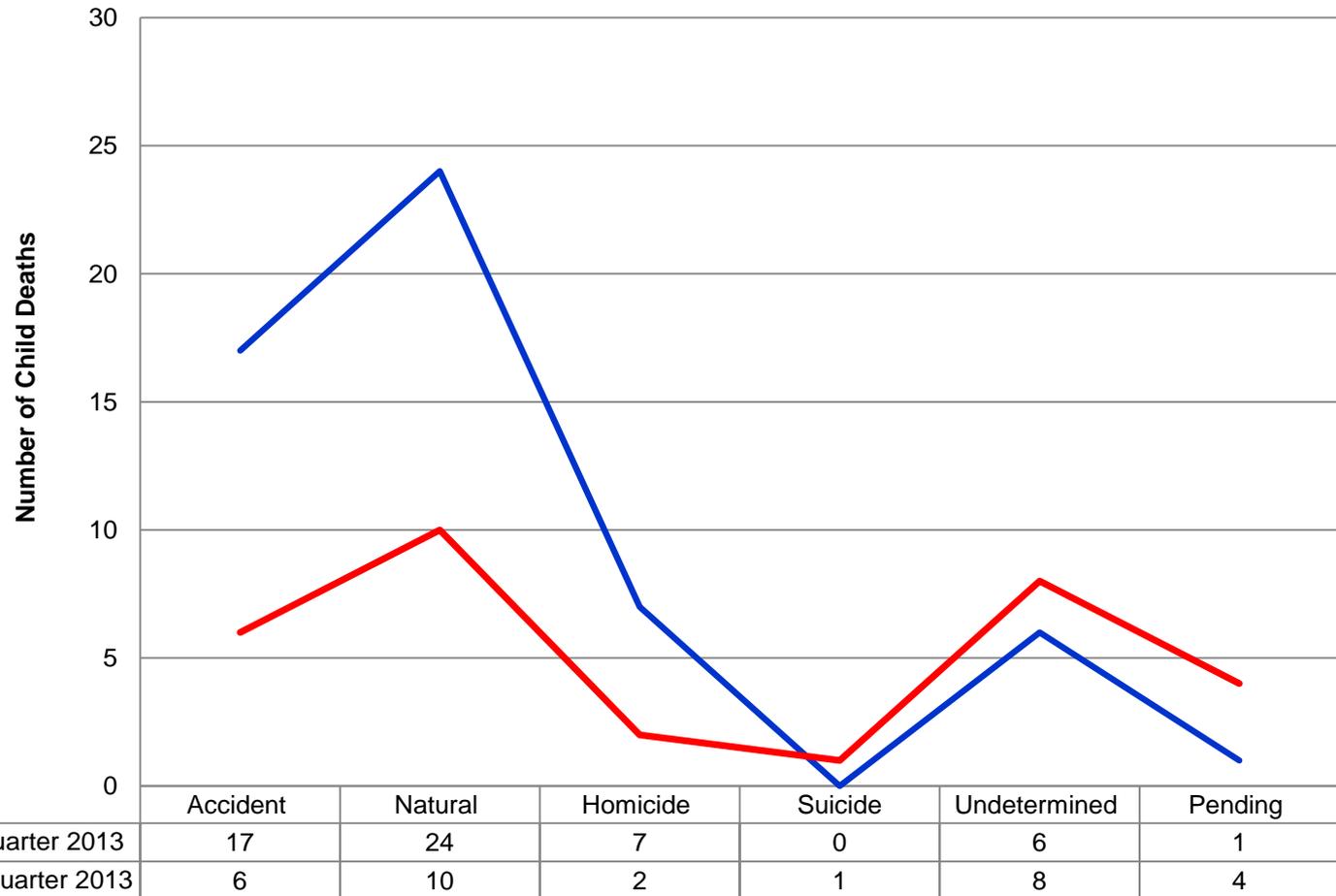


Manner of Child Deaths for Calendar Year 2013 (N=86)

Manner of Child Deaths



Manner of Deaths by QTR 2013



Note: Pending deaths are those in which the official cause and manner have not been determined

Causes: Deaths by Accidents & Natural Causes

Accidental Deaths (6)

- Drowning (2)
- Asphyxia Overlay/Co-Sleeping (3)
- Blunt Force Head Trauma Motor Vehicle Accident (1)

Natural Causes (10)

- Birth Related (3)
- Congenital or Pre-existing Medical Condition (6)
- Acute or Contracted Illness/Condition (1)

Causes : Deaths by Homicides, Suicides & Undetermined

Homicide (2)

- Abusive Trauma
Family Friend (1)
- Abusive Head Trauma
Babysitter (1)

Suicide (1)

- Self-Inflicted Gunshot Wound
Head

Undetermined Causes (8)

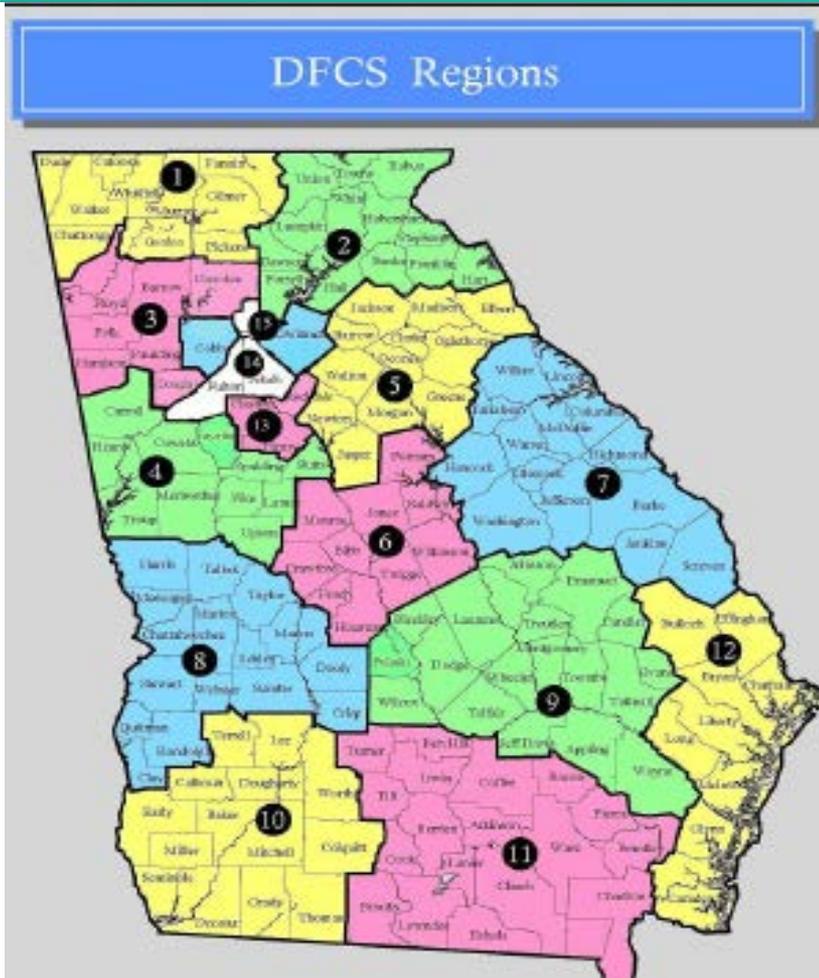
3 children (half-siblings) died in house fire due to soot and smoke inhalation; cause of fire currently undetermined ; 5 children causes undetermined, possible SUIDS in some cases

Pending Causes (N=4)

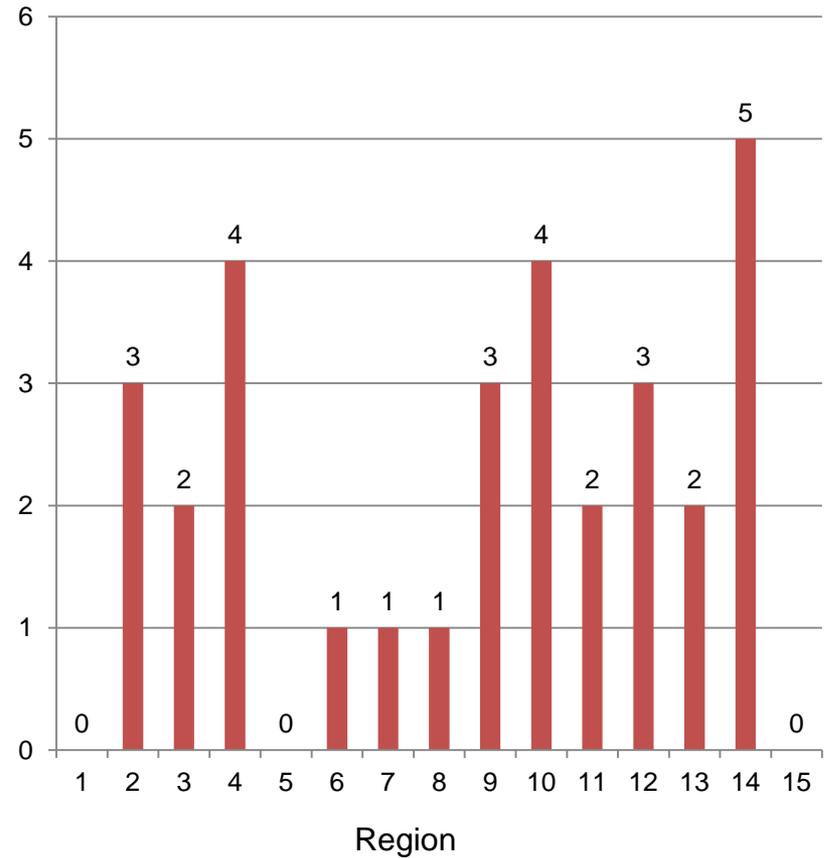
Currently, 4 deaths pending w/ official causes undetermined

- Sleep related (3)
- Child with head trauma, multiple bruises (1)

Child Deaths by DFCS Region



Number of Deaths



Causes of Child Deaths by Region (N=31)

- **R2** (3) 2 undetermined (possible SUIDS); 1 pending co-sleeping deaths
- **R3** (2) 1 Natural death/cirrhosis; 1 accident
- **R4** (4) 3 Undetermined deaths/unknown cause of house fire; 1 pending co-sleeping death
- **R6** (1) Pending sleep-related death
- **R7** (1) Medical death/extreme prematurity
- **R8** (1) Abusive trauma/suspected homicide by parent; no prior CPS history with family; agency took custody of child prior to death
- **R9** (3) 1 Head trauma/motor vehicle accident; 1 medical-related death; 1 undetermined
- **R10** (4) 2 Natural deaths/medical conditions; 1 homicide/babysitter; 1 accident
- **R11** (2) 1 Homicide/family friend, 1 pending medically fragile child/breathing difficulty
- **R12** (3) 2 Accidental drowning; 1 pending co-sleeping
- **R13** (2) 1 undetermined (SUIDS); 1 suicide by gunshot
- **R14** (5) 1 Accidental asphyxia /co-sleeping; 3 medical deaths/special needs children; 1 undetermined

Note: Parenthetical numbers indicate deaths for that region

Length of Time Between Prior DFCS Involvement & Child's Death

| Length of Time Between Prior DFCS Involvement w/ Family & Child's Death | Number of Children | Percent of Children |
|---|--------------------|---------------------|
| One Year or Less | 16 | 51.6% |
| Two Years | 7 | 22.6% |
| Three Years | 2 | 6.5% |
| Four Years | 1 | 3.2% |
| Five Years | 5 | 16.1% |

Note: 31 deaths include children in cases open at the time of their death for reasons unrelated to the death or unrelated to the incidents that led to the death

Type of DFCS History: 1st & 2nd Quarters 2013

| | January – March 2013 | April – June 2013 |
|--|----------------------|-------------------|
| Prior Investigation for abuse or neglect | 43 | 22 |
| Prior Family Preservation Services (services designed to prevent removal of children) | 16 | 5 |
| Prior Family Support (supportive services to families in which there are no safety concerns) | 14 | 5 |
| Previous Diversion (no maltreatment – short term support services) | 20 | 11 |
| Case opened at the time of child's death | 22 | 10 |
| Children in foster care at the time of his/her death | 8 | 4 |

Note: April – June, in addition to the above information, the only CPS history on one family was a screened-out report. The totals above are greater than 31 due to some families having involvement in more than one program area

Cases Open with DFCS at Time of Child's Death (N=10)

- **Foster Care (4):** 2 opened for foster care and investigations simultaneously (counted as foster care); 1 pending suspected abusive trauma; 1 ruled natural death due to heart defect
- **Investigations (3):** 1 death homicide by a visiting family friend who was reported to the agency the day before for allegedly molesting another child in the home; 2 reports of medical neglect on special needs children. Both reports of medical neglect were unsubstantiated and deaths were due to the children's medical conditions
- **Family Preservation (1):** Pending - suspected medical death
- **Family Support (2):** The cause of one death pending due to co-sleeping incident; one ruled natural death due to medical complications from extreme prematurity

Note: In addition to the above, there were 3 other child deaths in cases that were open with DFCS at the time of the child's death. However, there was no prior DFCS history. The cases were opened because of a report related to the incident surrounding the death.

Reasons for Deaths of Children in Foster Care at Time of Deaths (N=4)

- (2) Special-needs children w/ diagnosed medical conditions, i.e. cerebral palsy, seizures, reflux, tracheotomy, ventilator dependent, short gut syndrome; in foster care due to parents' inability to provide for special needs; and/or neglect/abuse issues related to the parent's overall caretaking abilities
- (1) Child entered care for suspicions of drug ingestion & need of heart transplant; Cause of death natural and was related to an undetected heart defect
- (1) Child entered care due to abusive trauma; death will likely be ruled a homicide; DFCS had no prior history on the child or his caretakers before this incident

NOTE: 3 of the 4 children died from medically-related conditions. The other child died as a result of the trauma sustained prior to coming into care

DFCS Case Staffings & Reviews

- Since January 2012, child deaths with suspected or alleged maltreatment and DFCS history have been reviewed and staffed between DFCS state office staff and regional and county staff as required. Staffings also include external stakeholders, e.g. Office of the Child Advocate, law enforcement and medical staff
- The goal is to review and staff cases within 24 hours in order to:
 - Obtain current case information, case history and circumstances of the death for immediate feedback to the Division Director and DHS Commissioner
 - Provide consultation and feedback to the county regarding case assessment and best decision-making for the safety and well-being of surviving children
 - Assess and determine services needed for the family
 - Analyze and improve practice in cases as issues are revealed.
 - Identify trends in order to implement prevention and practice strategies to reduce child maltreatment

Note: During the second quarter, 16 of the 31 child deaths were staffed.

2nd QTR Trends: April 2013 through June 30, 2013

Sleep-Related Deaths

10 of the 31 deaths occurred during a sleep-related incident

- 6 of the 10 cases reported co-occurring drug or alcohol use by the caretaker
- 7 of the 10 children were co-sleeping at the time of their death
- 3 of the 10 children were in unsafe or questionable sleep environments
 - Infant in cast from hip dysplasia; diagnosed w/ RSV; propped on an adult bed with coats used as a support
 - 4 mo old in bassinet atop pillows & rolled-up blankets; child left unchecked 9 hours
 - Infant reportedly placed on stomach in pack and play; caretaker had used controlled substance

2nd QTR 2013 Findings & Recommendations

- Intake decision-making must include examining the constellation of findings associated with emerging dangers that impact child safety, even when an incident of maltreatment is not readily identified
- Cases with identified high risk factors should be staffed with medical professionals and more frequently with experienced DFCS management staff
- Maternal drug use co-occurring with the birth of premature infants; caregiver drug use has great potential to negatively impact parental and protective capacities, and to increase child vulnerability
- Greater focus is warranted on assessing substance abuse and its potential impact on the safety and well-being of children and families
- Staff need more education and training about drugs, drug usage, addiction, and the impact of drug use on caregiver behavior and child safety

Strategies to Improve Outcomes for Children

- Working w/ Department of Public Health to enhance data collection, tracking, information sharing & reporting of child death cases in Georgia
- Developing live-learning template on serious injury & child deaths to improve DFCS offices' decision-making & assessment of child safety
- Providing consultation & support for counties on cases of child deaths and serious injury, frequently including medical experts from Children's Health Care of Atlanta (CHOA)
- Working w/ Georgia Bureau of Investigation (GBI) to promote partnership in gathering child death information & utilizing GBI's resources
- Partnering with CHOA to develop more in-depth analyses of medically- related deaths

Division of Family & Children Services: Third Quarter 2013 Child Death Report (July – September, 2013)

Date of Presentation: January 13, 2013



Georgia Department of Human Services

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Summary: Child Deaths with Prior DFCS History

- Of the 45 deaths reported to DFCS during the 3QTR13, 80% of known causes were due to accidents or natural causes
- Nearly 70% of children were age four and under
- Almost half of the deaths were related to children with special needs, particularly severe medical issues
- Sleep-related deaths continue to be a causal factor in child deaths
- 4 children were in foster care at the time of death; two were related to serious illness, one was a suicide and another is undetermined

Child Death Comparison between 2012 & 2013

At the end of the 3rd quarter, our data shows an increase in the number of deaths reported to DFCS from 2012 to 2013. This could be in part due to improved data collection within DFCS. Our partnership with GBI and access to their data on child deaths, has heightened awareness & more deaths have been captured.

| Year | 1 st QTR (Jan-March) | 2 nd QTR (April-June) | 3 rd QTR July-September | Total |
|------|------------------------------------|-------------------------------------|---------------------------------------|-------|
| 2012 | 46 | 39 | 35 | 120 |
| 2013 | 55 | 31 | 45 | 131 |

Note: This information reflects only those children in families who had any DFCS child welfare involvement during the five years prior to the death occurring.

Classifying Child Deaths by Cause and Manner

- Cause of Death refers to a forensic finding of how the death occurred (drowning, gunshot, suffocation, etc.).
- Manner of Death is an official finding of how the cause of death arose:
 - Accidental
 - Homicide
 - Natural
 - Suicide
 - Undetermined (when it is medically impossible to establish the circumstances of death)

Third Quarter 2013: Manners of Child Deaths (N=45)

| | July | August | September | Total |
|--------------|-----------|-----------|-----------|-----------|
| Accident | 3 | 2 | 2 | 7 |
| Natural | 7 | 1 | 5 | 13 |
| Homicide | 1 | 0 | 1 | 2 |
| Suicide | 0 | 3 | 0 | 3 |
| Undetermined | 1 | 2 | 2 | 5 |
| Pending | 2 | 5 | 8 | 15 |
| Total | 14 | 13 | 18 | 45 |

Pending deaths are those in which information is still being processed by the medical examiner in order to make a finding while undetermined manner of death means that a medical finding was unable to clearly identify the cause & manner

Causes : Deaths by Accidents & Natural Causes

Accidental Deaths (7)

- Drowning (2) 1 child in a bathtub, 1 found in a pond
- Vehicle vs. Pedestrian (1) toddler run over in driveway
- Motor vehicle accident (3) 2 children from 1 family were killed in one accident, 1 child killed in car accident
- Drug (heroin) overdose (1 teen)

Natural Causes (13)

- Congenital or Pre-existing Medical Condition (9) e.g. short gut syndrome, cerebral palsy, thyroid disease
- Birth Related (1) extreme prematurity
- Acute or Contracted Illness/Condition (2) undetected heart condition, infection after birth
- Undetermined (1) mother co-sleeping with medically fragile child with heart condition and breathing difficulties.

Causes : Deaths by Homicides, Suicide & Undetermined

Homicide (2)

- Gunshot by 3rd party (1)
- Traumatic Brain Injury (1)

Suicide (3)

- Gunshot (1)
- Hanging (2)

Undetermined (5)

- Complications from dehydration and prematurity (1)
- SUIDS – Sudden Unexplained Infant Death (2) unsafe sleeping environments
- Unclear (1) co-sleeping was a factor & autopsy could not definitively identify cause
- Undetermined (1) Medical Examiner could not determine cause and circumstances were suspicious.

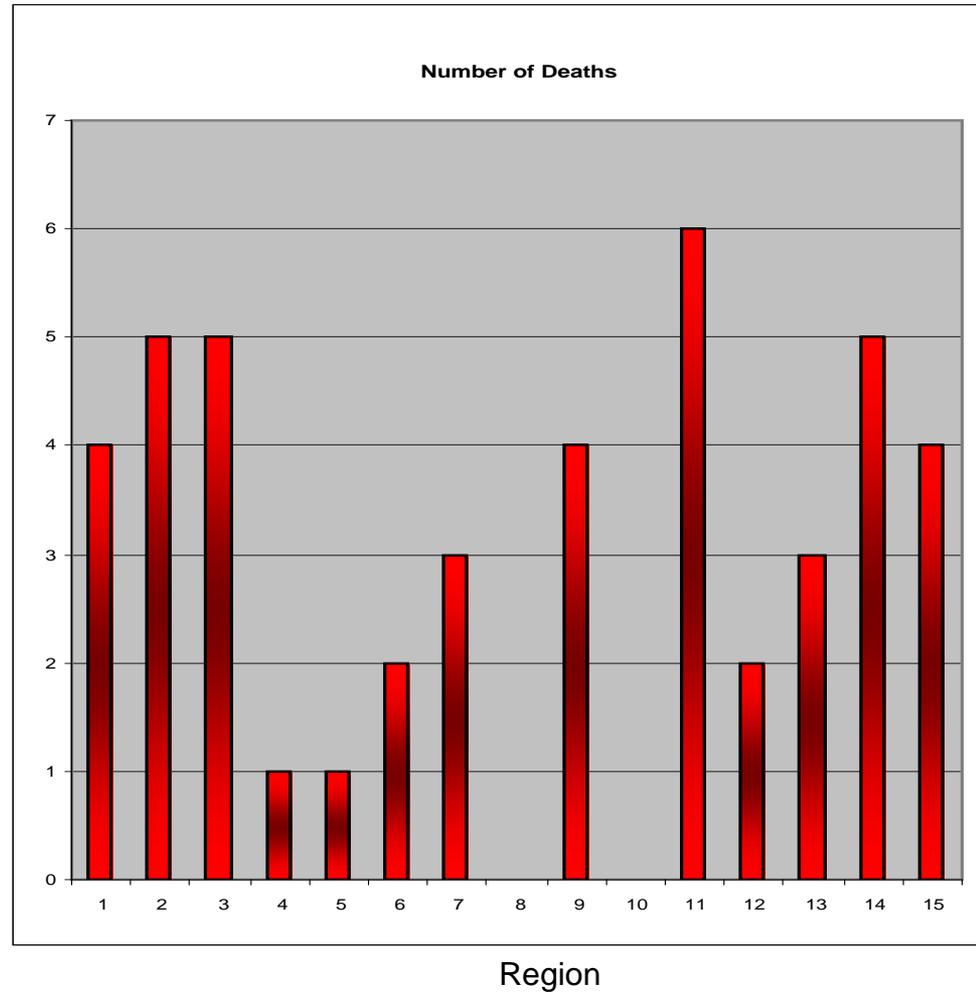
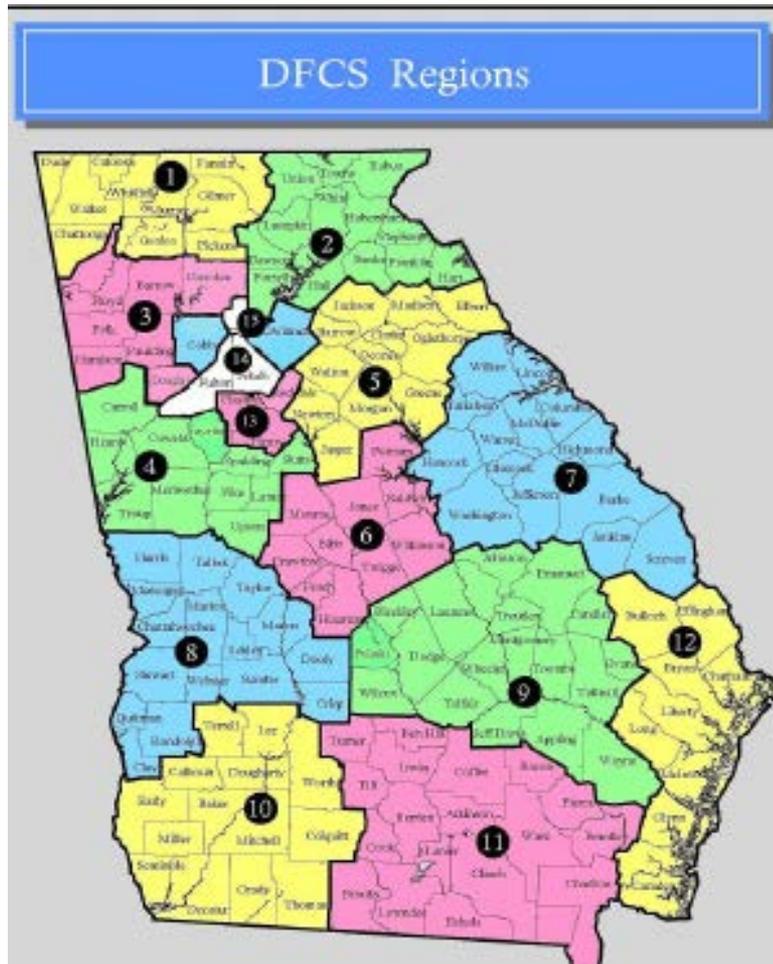
Pending Causes (15)

Deaths where the official cause and manner has not been determined and are still pending with the medical examiner's office:

- Sleep related (2) co-sleeping
- Suspected non-accidental trauma (6)
- Medical related (2)
- Unknown/found unresponsive, stopped breathing, or undetermined (4)
- Run over in driveway (1)

Note: Pending deaths are those in which information is still being processed by the medical examiner in order to make a finding.

Child Deaths by DFCS Region



Causes of Child Deaths by Region

- R1 (4) Medical – 2; pending co-sleeping; accidental drowning
- R2 (5) Medical/natural - 2; suicide/hanging - 2; accidental heroin overdose
- R3 (5) Prematurity/genetic; Motor Vehicle Accident - 3; pending homicide
- R4 (1) Suicide by gunshot
- R5 (1) Accident/run over in driveway
- R6 (2) Pending homicide; pending found unresponsive
- R7 (3) Medical/natural -2; undetermined/unclear due to sleep environment
- R9 (4) Homicide/Traumatic Brain Injury; accidental drowning; undetermined SUIDS; Natural/medical
- R11 (6) Natural/medical - 2; pending - run over in driveway; undetermined SUIDS; pending homicide; pending found unresponsive
- R12 (2) Undetermined; pending homicide
- R13(3) Undetermined/medical; pending homicide; pending unknown
- R14 (5) Natural/medical - 2; Natural/undetermined; pending co-sleeping; pending unresponsive
- R15(4) Pending natural/medical - 2; pending gunshot; homicide/gunshot

Note: Number in parentheses indicates the number of deaths for that region.

Type of DFCS History: Third Quarter 2013 Child Deaths

| | July 2013 – September 2013 |
|---|----------------------------|
| Prior Investigation for abuse or neglect | 30 |
| Prior Family Preservation Services (in-home support for the family) | 11 |
| Prior Family Support | 11 |
| Prior Diversion case (no maltreatment –short term support services) | 12 |
| Case open at the time of child death | 21 |
| Children in foster care at the time of his/her death | 4 |



*Note: The above total is greater than 45 due to some families having more than 1 type of prior intervention. Additionally the only history for 5 families was a prior screen out before the agency learned of the death.

Length of Time between Prior DFCS Involvement & Child's Death (N=45)

| Length of Time between Prior DFCS Involvement with Family & Child's Death | Number of Children | Percent of Children |
|---|--------------------|---------------------|
| One Year or Less* | 31 | 69% |
| Two Years | 7 | 16% |
| Three Years | 6 | 13% |
| Four Years | 1 | 2% |
| Five Years | 0 | N/A |

Note: This number also includes children in cases that were open at the time of the child's death for reasons unrelated to the death or the incident that led to the death occurring. e.g. one case involved a child born testing positive for illegal drugs but the child died due to extreme prematurity.

Reasons for death of children in foster care (4)

- Three children were diagnosed as medically fragile and/or special needs. Two of the three died due to complications related to their illness; the third child's death is still under review by the medical examiner to determine if neglect suffered prior to entering foster care impacted the child's overall health & ultimately related to the death.
- One child in foster care committed suicide by hanging. The child was diagnosed with mental health disorders and was actively in treatment at the time of death.

Reasons for Death of Children in Open Investigations (11)

- 3 cases were opened due to the injury that resulted in the death of the child & are suspected homicides.
- 2 children died after birth never leaving the hospital.
- 2 children died in one car accident. (17 year old teen mother and her one year old child).
- 2 children died while co-sleeping.
- 2 children died due to complications from medical conditions.

Reasons for Death of Children in Family Preservation Cases (6)

- Child had complicated medical condition & caretaker was demonstrating understanding & compliance in meeting medical needs; a missed lab appointment to regulate medicine resulted in fatal outcome.
- Child was born drug positive; young parents (ages 16 & 19); agency filed court intervention and obtained protective order to ensure parent's compliance; child was found to have non-accidental trauma & death is a suspected homicide.
- Caretaker was co-sleeping with child and other siblings.

Reasons for Death of Children in Family Preservation Cases (Cont.)

- Child born drug positive and caretaker stated child was found unresponsive in crib – Cause and Manner still pending.
- Child was in home of a relative to assist in caring for child and relative found child unresponsive in crib - Cause and Manner still pending.
- Child developed a viral infection that spread to heart and died 3 days after birth.

DFCS Case Staffings & Reviews

- Since January 2012, child deaths with suspected or alleged maltreatment; or unknown circumstances and DFCS history have been reviewed and staffed between DFCS state office staff and regional and county staff as required. Staffings may also include external stakeholders, e.g. Office of the Child Advocate, law enforcement and medical personnel.
- The goal is to review and staff cases within 24 hours of the notification in order to:
 - Obtain current case information, review case history and circumstances of the death for immediate feedback to the Division Director and DHS Commissioner.
 - Provide consultation and feedback to the county regarding case assessment and best decision-making for the safety and well-being of surviving children.
 - Assess and determine services needed for the family.
 - Analyze and improve case practice as issues are revealed.
 - Identify trends in order to implement prevention and practice strategies to reduce child maltreatment.

Note: During the third quarter, 29 of the 45 child deaths were staffed.

3rd Quarter Trends: July 2013 through September 30, 2013

- 18 children were identified as having **special medical needs**. Their medical condition was either directly related to their death or was a contributing factor in their death.
- 16 cases reported, alleged substance abuse/use by the child's caretaker.
- 7 children died while in an unsafe sleep environment or were co-sleeping with siblings or adults at the time of their death.
- 12 families had either past or present allegations of domestic violence.

3rd Quarter 2013 Findings & Recommendations

- Intake decision-making must continue to include examining the constellation of findings associated with emerging dangers that impact child safety, even when an incident of maltreatment is not readily identified. CPS History must be evaluated at the point of Intake to help identify the needed agency response.
- Cases with identified high risk factors should be staffed more frequently with experienced DFCS management staff. Additional staff training on how to recognize & identify maltreatment – specifically when a neglectful situation of a caretaker results (unintentionally) in a negative outcome for a child.
- Greater focus is warranted on assessing special needs children and the need for involving medical professionals in the assessment of children and their ongoing medical needs. Enhanced collaboration with medical professionals to verify compliance of medical treatment on reports of medical neglect.
- Maternal drug use co-occurring with the birth of premature infants; caregiver drug use has great potential to negatively impact parental and protective capacities, and to increase child vulnerability
- Staff need more education and training about the impact substance abuse, untreated mental health and domestic violence can have on children. Specifically when caretakers deny their presence.



Some identified High Risk Factors are: Untreated Mental Health, Substance Abuse, Domestic Violence, Medically Fragile Children, Prior DFCS History.

Strategies to Improve Outcomes for Children

- Partnering with the Cherokee Child Advocacy Center to develop and administer an intensive training on how to interview children to gain the best information to make decisions regarding their safety; all DFCS case managers who conduct investigations and work with Family Support Cases will be required to attend
- Partnering with Georgia Public Safety Training to develop training on most effective methods of interviewing adults in order to improve decisions we make regarding their ability to appropriately ensure the safety of their children; all DFCS case managers who conduct investigations and work with Family Support Cases will be required to attend
- Developing an external review process to assess current DFCS practice to determine areas of improvement
- Conducting predictive analytics on child deaths to determine commonalities (red flags) that may be indicators that child is not safe

Strategies to Improve Outcomes for Children

- Continue working with Department of Public Health to enhance data collection, tracking, information sharing & reporting of child death cases in Georgia
Working w/ Georgia Bureau of Investigation (GBI) to promote partnership in gathering child death information & utilizing GBI's resources
- Developing live-learning formats on serious injury & child deaths to improve DFCS offices' decision-making & assessment of child safety
- Providing consultation & support for counties on cases of child deaths and serious injury, frequently including medical experts from Children's Health Care of Atlanta (CHOA)
- Providing training to staff on assessing medically fragile children and share information as it is gathered through the child death staffing process.
- Integrating county staff in developing a safety review process on identified high risk cases
- Partnering with CHOA to develop more in-depth analyses of medically - related deaths